

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

00 - 2000

2. STATE:

New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 5, 2000

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) =

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902(a)(13)(A) of the Social Security Act
42 CFR 447, Subpart C; 447.253

7. FEDERAL BUDGET IMPACT:

a. FFY 2000 \$ 4.27 million

b. FFY 2001 \$ 19.2 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A

Pages 158

158.1

159

*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19A

Supersedes Page 158

New Page

Supersedes Page 159

10. SUBJECT OF AMENDMENT:

Additional Payments for Medicaid Managed Care

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Exempt pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michele K. Guhl

14. TITLE:

Commissioner

15. DATE SUBMITTED:

16. RETURN TO:

Division of Medical Assistance
and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

RECEIVED

HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

WASHINGTON, D.C. 20492

FEDERAL REGISTER

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- x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;
 - xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and
 - xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid recipients) and that the hospital is necessary to provide access to care for Medicaid recipients.
- (b) The Division shall review the documentation and determine if an adjustment is warranted.
- (c) The Division shall issue a written determination with an explanation as to each request for a rate adjustment. If a hospital is not satisfied with the Division's determination, they may request an administrative hearing pursuant to N.J.A.C. 10:49-10. If a hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence or documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying or rejecting the Administrative Law Judge's initial Office of Administrative Law Decision. Thereafter, review may be had in the Appellate Division.

00-20-MA (NJ)

Supersedes 97-03

TN 00-20 Approval Date JUN 06 2001
Supersedes TN 97-03 Effective Date AUG 05 2000

10.1 Additional Payments for Medicaid Managed Care

- a) Hospitals eligible to receive a Hospital Relief Subsidy Fund (HRSF) payment shall receive enhanced payments from the Medicaid program for providing services to Medicaid and New Jersey FamilyCare – Plan A beneficiaries.
- b) Total enhanced Medicaid managed care payments shall be allocated among hospitals proportionately based on the amount of HRSF payments (excluding any adjustments to the HRSF for other Medicaid payment increases).
- c) Effective for services rendered after August 4, 2000, interim payments shall be made monthly in equal lump sum amounts, based on an estimate of the total enhanced amount payable to a qualifying hospital, subject to cost settlement.
- d) Final enhanced payments shall be determined at cost settlement and shall be calculated as follows: \$750 per Medicaid patient day, adjusted by a volume variance factor (the ratio of expected Medicaid inpatient days to actual Medicaid inpatient days for the rate year) and an HRSF factor (the ratio of the hospital's HRSF payments to total HRSF payments) and subject to a pro rata adjustment so that the total enhanced per diem amounts equal the total State and Federal funds appropriated in the fiscal year for these payments.

00-20-MA(NJ)

New Page

TN 00-20 Approval Date JUN 06 2001
Supersedes TN **New** Effective Date AUG 05 2000

SECTION 1 APPENDIX**1.1 DEFINITIONS**

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

"Adjusted admissions" means inpatient admissions increased to reflect outpatient activity and is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"Base year" means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

"Current Cost Base" means the actual costs and revenue of the hospital as identified as the Financial Elements in the base reporting period for the purposes of rate Setting.

"Commission" means the Hospital Rate Setting Commission.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications and consuming a similar amount of resources.

00-20-MA (NJ)

Supersedes 93-11

TN 00-20 Approval Date JUN 06 2001
Supersedes TN 93-11 Effective Date AUG 05 2000